mental health or substance abuse services are provided to managed care Medicaid recipients. See Sections III.A and III.B.

The regions used to develop the all-inclusive regional weighted average per diem rates correspond to the six Health Services Areas established by the Massachusetts Department of Mental Health (PL93-641). These regional weighted average per diems were calculated by a) dividing each hospital's per discharge psychiatric rate established in the FY92 Medicaid RFA by the FY90 average length of stay pertaining to Medicaid psychiatric patients; b) multiplying the result for each hospital by the ratio of the hospital's Medicaid mental health days to the total Medicaid mental health days for the hospital's region; and c) summing the results for each region. The regional weighted average per diems were updated using inflation factors of 3.35% to reflect price changes between RY92 and RY93; 3.01% to reflect price changes between RY93 and RY94; and 2.80% to reflect price changes between RY94 and RY95.

For hospitals which are part of the Division's MH/SA provider network, the lower of the MH/SA negotiated rate or the psychiatric per diem shall be the rate of payment in all cases where the psychiatric per diem established in the RFA applies.

b. ***Payment for Psychiatric Services in Department of Mental Health (DMH) Replacement Units***

Year of Start-Up

Replacement unit services will be reimbursed through a prospective per diem payment which is based on the specific hospital's contracted allowable costs for replacement services and total projected days of replacement services.

Medicaid allowable costs will be based on a budget which represents a maximum level of reasonable and adequate reimbursable expenditures which will be recognized by the Medicaid program. Costs incurred in excess of this budget will not be reimbursed by Medicaid since each DMH Replacement Unit budget is based on an analysis which determined the reasonable and adequate costs which must be incurred in the efficient and economic provision of services. The hospital must prepare a detailed budget using its chart of accounts which can be summarized into the following cost categories:

A. Direct Costs
B. Physician Costs
C. Ancillary Costs
D. Major Moveable Equipment
E. Capital Costs
F. Indirect Costs

Direct Costs are the approved costs of staff salaries and fringe benefits, and

supplies and expenses incurred in the unit. These include costs such as unit director, nursing staff, psychologists, social workers, therapists, mental health workers, and other staff directly assigned to the replacement service. Other expenditures such as contracted management services, liability insurance, and legal consultants should also be classified as Direct Costs. The cost of psychiatrists and physicians, including the medical director, should be classified as Physician Costs. Also included in Physician Costs should be medical and neurological consultants and physician on-call coverage.

Ancillary service costs will be included by estimating charges for ancillary services provided to patients in replacement units and multiplying by the hospital-specific aggregate ancillary cost-to-charge ratio. This cost-to-charge ratio will be determined using the most recent RSC-403 ancillary costs adjusted to include capital expenses. Hospitals may not separately bill Medicaid for the professional component. The cost-to-charge ratio must be applied to all ancillary charges for services delivered to patients in replacement beds which customarily will include the following revenue codes:

Pharmacy (25x)
IV Therapy (26x)
Oncology (28x)
DME (29x)
Respiratory Therapy (41x)
Physical Therapy (42x)
Occupational Therapy (42x)
Speech & Language Therapy (44x)
Audiology (47x)
Pulmonary Function Test (46x)
Cardiology (48x)
Osteopathic (53x)
EKG (73x)
EEG (74X)
Gastrointestinal (75x)
Observation or Treatment Room (76x)
Lithotripsy (79x)
Other Donor Bank (89x)
Psychiatric Treatment (90x)
Psychological Services (910,911,914-919)
General Classification - DX Services (920)
Allergy Test (924)
Other DX Services (929)
Other Therapeutic Services (94x)

In addition to the costs described above, Indirect and Capital Costs will be allowed in the rate.

Allowable Indirect Costs will be those reported in the prior year RSC-403 inflated

to the rate year. Indirect Costs and cost centers which will be reviewed include:

Administration	*Nursing Administration*
Plant Maintenance	*Housekeeping*
Plant Operations	*Medical Records*
Laundry and Linen	*Social Services*
Dietary	*Medical Teaching*
Cafeteria	*Other (describe)*

Capital costs include allocated costs for depreciation and interest associated with existing plant and equipment. In addition, the projected amortized costs attributable to renovations that are allowed in the contract will also be recognized as allowable Medicaid costs after being stepped down using the RSC-403 methodology. Major moveable equipment will be separately identified and directly costed to the replacement service in the same method used on the RSC-403. Upon determination of total Medicaid allowable costs, the state will project patient volume (days and discharges) by payor.

The Medicaid prospective per diem rate will, however, be subject to the following limit. Medicaid charges cannot exceed the amount that would be charged to other payors. Medicaid reimbursement, during an approved admission, will be limited to the lower of aggregate charges or the product of the per diem rate times the number of applicable Medicaid days for the replacement service.

Second Program Year and Subsequent Years

The Department will utilize the same process to calculate a prospective per diem rate for each hospital's second and subsequent program years. However, several cost categories will be updated to reflect actual cost experience in the prior year. These cost categories include:

1. *Direct Costs - will be adjusted to reflect actual staffing patterns, overtime requirements, contracted expenses including management fees, and cost of supplies. Adjustments to and cost of the original direct care assumptions may be made at this time, and the adjusted costs will be updated for inflation.*

2. *Physician Costs - will be adjusted to reflect actual physician staffing, changes in compensation arrangements, on-call coverage requirements and inflation.*

3. *Ancillary Costs - will be adjusted to reflect prior year actual utilization levels and updates cost-to-charge ratios.*

4. *Major Moveable Equipment - will be updated to reflect actual expenditures.*

5. *Capital Costs - will be adjusted to reflect actual costs of approved renovations.*

6. *Indirect Costs - will be updated to reflect the most current RSC-403 Cost Report.*

Upper Limit Adjustment and Federal Approval

Payment for DMH replacement units may be subject to an upper limit adjustment for any service year, based on an aggregate upper limit finding for all Medicaid acute hospital services.

If any portion of the reimbursement methodology is not approved by the Health Care Finance (HCFA) the state will recoup any payment made to the hospital in excess of the approved methodology.

8. ***Outlier Payments***

Eligibility

*A hospital qualifies for an outlier per diem payment in addition to the standard payment amount if **all** of the following conditions are met:*

- *the length of stay for the hospitalization exceeds twenty (20) cumulative acute days (not including days in a distinct part psychiatric unit);*
- *the hospital continues to fulfill its discharge planning duties as required in the Division's regulations;*
- *the patient continues to need acute level care and is therefore **not** on administrative day status on any day for which an outlier payment is claimed;*
- *the patient is not a patient in a distinct part psychiatric unit on any day for which an outlier payment is claimed; and*
- *the patient is not a patient in a chronic unit (as defined in Section IV.2.A.13) for which a chronic per diem has been established.*

The outlier per diem payment amount is equal to fifty-five percent (55%) of the statewide standard payment amount per day times the hospital's wage area index and casemix index, plus a per diem payment for the hospital's pass-through costs, direct medical education and capital payment amounts.

To derive the standard payment amount per day, the standard payment amount per discharge of $2,346.78 is divided by the average FY90 Medicaid length of stay of 5.35 days, which equals $438.65. The pass-through and reasonable capital cost per diem payments equal the hospital's pass-through costs, direct medical education and capital payments per discharge divided by the hospital's Medicaid length of stay.

9. **Transfer Per Diem Payments**

a. **Transfer Between Hospitals**

In general, payments for patients transferred from one acute hospital to another will be made on a transfer per diem basis (capped at the per discharge payment) for the hospital that is transferring the patient. The amount of the transfer per diem payment is equal to the RY95 statewide standard payment amount per day, adjusted by the transferring hospital's RY95 Medicaid casemix index and wage area index, plus pass-through, direct medical education and capital per diem payments.

To derive the standard payment amount per day for transfer patients, the RY95 standard payment amount per discharge of $2,346.78 is divided by the FY90 average Medicaid length of stay of 5.35 days, which equals $438.65. The pass-through, direct medical education and capital per diem payments equal the hospital's pass-through, direct medical education and capital costs per discharge divided by the hospital's Medicaid length of stay.

In general, the hospital that is receiving the patient will be paid on a per discharge basis in accordance with the standard methodology specified in Sections IV.2.A.2 - IV.2.A.5, above, if the patient is actually discharged from that hospital. If the patient is transferred to another hospital, then the transferring hospital will be paid at the hospital's specific transfer per diem rate, capped at the hospital-specific per discharge amount. Additionally, "back transferring" hospitals will be eligible for outlier payments specified in Section IV.2.A.8 above.

An acute care hospital receiving a patient from a DMH Replacement Unit within another acute care hospital will be paid at its per discharge payment amount (SPAD). DMH Replacement Unit rates are governed by separate contracts between hospitals, DMH and the Division.

*Refer to matrices (attached as **Exhibit 3**) for a review of transfer scenarios and corresponding payment mechanisms involving managed care recipients and non-managed care recipients in MH/SA network and non-network hospitals.*

b. **Transfers within a Hospital**

*In general, a transfer within a hospital is not considered a discharge. Consequently, in most cases a transfer between units within a hospital will be reimbursed on a per diem basis. This section shall outline reimbursement under some specific transfer circumstances. For a complete review of reimbursement under transferring circumstances involving managed care recipients and non-managed care recipients in MH/SA network and non-network hospitals, refer to the matrices (attached as **Exhibit 3**).*

(1) ***Transfer to\from a Chronic Unit within the Same Hospital***

If a patient is transferred from an acute bed to the chronic unit in the same hospital, the transfer is considered a discharge. The Division will pay the SPAD for the portion of the stay before the patient is transferred to a chronic unit. In addition, the hospital will bill its hospital-specific chronic per diem for each chronic level of care day that the patient is in the Chronic Unit.

(2) ***Medicaid Payment in the Event of Exhaustion of Other Insurance***

When a patient becomes Medicaid-eligible because other insurance benefits have been exhausted, the acute stay will be paid at the transfer per diem rate, up to the hospital-specific per discharge amount, or, if the patient is at the administrative day level of care, at the AD per diem rate.

(3) ***Admissions Involving One-Day Length of Stay Following Ambulatory Surgery***

If a patient is admitted for a one-day stay following ambulatory surgery, the hospital shall bill at the transfer per diem rate instead of the hospital-specific per discharge payment amount.

(4) ***Transfer between a Distinct Part Psychiatric Unit and Any Other Bed within the Same Hospital***

*Reimbursement for a transfer between a distinct part psychiatric unit and any other bed within a hospital will vary depending on the circumstances involved, such as managed care status, MH/SA network or non-network hospital, DMH replacement bed, or the type of service provided. Please refer to the matrices (attached as **Exhibit 3**) for reimbursement under specific transfer circumstances involving psychiatric stays.*

(5) ***Change of Managed Care Status during a Psychiatric or Substance Abuse Hospitalization***

(a) ***Payments to hospitals without network affiliation agreements with the Division's Mental Health/Substance Abuse (MH/SA) Provider.***

When a recipient becomes assigned to managed care during a non-emergency or emergency psychiatric hospital or substance abuse stay at a non-network hospital, the portion of the hospital stay during which the recipient was assigned to managed care shall be paid by the Division's MH/SA provider at the transfer per diem rate, capped at the per discharge payment, for substance abuse services and at the psychiatric per diem rate for mental health services. The portion of the hospital stay during which the recipient was not assigned to managed care will be paid by the Division at the psychiatric per diem rate for psychiatric services or at the transfer per diem rate for substance abuse services.

(b) ***Payments to hospitals with network affiliation agreements with the Division's MH/SA Provider.***

When a patient becomes assigned to managed care during an emergency or non-emergency psychiatric or substance abuse hospital stay, the portion of the hospital stay during which the recipient was assigned to managed care shall be paid by the Division's MH/SA provider at the per diem rates agreed upon by the hospital and MH/SA provider.

The portion of the hospital stay during which the recipient was not assigned to managed care will be paid by the Division at the psychiatric per diem for psychiatric services or at the transfer per diem rate for substance abuse services.

10. ***Payment Rates for Inpatient Hospital Services Provided to Medicaid Recipients Enrolled in Health Maintenance Organizations (HMOs)***

The methodology described in Section IV.2.A shall apply to rates for Medicaid recipients enrolled in HMOs except for the following:

- *A separate casemix index shall be calculated for disabled recipients (as defined in Section II) and applied to the RY95 statewide standard payment amount. This will result in a distinct and separate per discharge rate, outlier rate and transfer rate which shall apply to disabled recipients enrolled in HMOs.*

- *A separate casemix index shall be calculated for non-disabled recipients (all other categories of assistance) and applied to the RY95 statewide standard payment amount. This results in a distinct and separate per discharge rate, outlier rate and transfer rate which shall apply to all Medicaid recipients enrolled in HMOs, except disabled recipients (as defined in Section II).*

If an HMO offers to pay a hospital a rate equivalent to that hospital's applicable RFA rate for services to the HMOs Medicaid enrollees, that hospital is required to accept the HMOs rate offer as payment in full for those enrollees.

This requirement does not preclude an HMO from choosing to pay any hospital at a rate higher or lower than the hospital's applicable RFA rates for services to the HMOs Medicaid enrollees.

11. ***Payments for Administrative Days***

Payments for administrative days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all AD days in all acute care hospitals.

- *The AD rate is comprised of a base per diem payment and an ancillary add-on.*
- *The base per diem payment is the average nursing home rate for acuity categories six to ten, effective January 1, 1992, as determined by the Bureau of Long Term Care, Massachusetts Rate Setting Commission. This base rate is $107.92.*
- *The ancillary add-on is based on the ratio of ancillary charges to "room and board" charges, calculated separately for Medicaid/Medicare Part B eligible patients and Medicaid-only eligible patients on AD status, using Medicaid claims for the period October 1, 1991 to September 30, 1992. These ratios are 0.0665 and 0.2969, respectively. The resulting AD rates (base and ancillary) were then updated for inflation using the update factors of 3.01% for RY94 and 2.80% for RY95.*
- *The resulting AD rates for RY95 are $121.81 for Medicaid/Medicare Part B eligible patients and $148.12 for Medicaid-only eligible patients.*

Medicaid rules and regulations do not allow a patient to be admitted at an AD status, except in limited circumstances outlined in the Provider Manual. In most cases, therefore, AD days will follow an acute stay in the hospital.

A hospital may receive outlier payments for patients who return to acute status from AD status after 20 cumulative acute days in a single hospitalization. That is, if a patient returns to acute status after being on AD status, the hospital must add the acute days preceding the AD status to the acute days following the
AD status in determining the day on which the hospital is eligible for outlier payments. The hospital may not bill for more than one SPAD where the patient fluctuates between acute

status and AD status; the hospital may only bill for one SPAD (covering 20 cumulative acute days), and then for outlier days, as described above.

12. ***Upper Limit Review***

The federal government requires that states certify that inpatient hospital payments in the aggregate do not exceed the amount of payments that would result if payments were based on the Medicare principles (TEFRA).

The Division has conducted a preliminary calculation of anticipated expenditures for hospital services under the new reimbursement methodology and compared it to the approximate amount that would be paid under TEFRA principles. The projected aggregate payment did not exceed the TEFRA estimated payment amount. Therefore, according to the Division's preliminary analysis, the proposed methodology meets the TEFRA upper limit test.

Since an upper limit method is calculated and applied to hospitals in the aggregate, adjustments may be needed if the number of hospitals that apply and qualify changes after the original analysis is done, updated information necessitates a change, or as otherwise required by the Health Care Financing Administration (HCFA).

13. ***Chronic Per Diem***

If in the FY90 base year, a hospital had a designated unit within the hospital of twenty-five (25) beds or more, a chronic per diem was calculated. When a patient is admitted directly to a chronic unit, a hospital must bill the hospital-specific chronic per diem. There will be no outlier payments for patients in chronic units. This rate is based on the hospital's actual costs (as reported on the FY90 RSC-403) for chronic services delivered to Medicaid recipients. This rate shall be paid for every day that is considered hospital level of care according to the Division's regulations. This per diem is all inclusive and represents payment in full for all chronic services. The derivation of the chronic per diem is as follows:

(a) A routine Cost-to-Charge Ratio (CCR) was calculated using routine chronic costs from the FY90 Medicaid claims data RSC-403, less major moveable equipment, divided by routine chronic charges from the FY90 RSC-403. (b) The result was multiplied by the Medicaid chronic routine charges from the FY90 Medicaid claims data file to obtain routine Medicaid costs. (c) The routine costs were added to the ancillary chronic Medicaid costs (which were also derived from the ancillary CCR, multiplied by FY90 Medicaid chronic ancillary charges) to obtain the total Medicaid chronic costs. (d) The total Medicaid chronic costs were divided by FY90 Medicaid chronic days (from the Medicaid claims data file) and added to the updated FY91 hospital-specific capital pass-through amount to arrive at the chronic per diem. The per diem was updated using inflation factors of 3.35% to reflect price changes between RY92 and RY93; 3.01% to reflect price changes between RY93 and RY94; and 2.80% to reflect price changes between RY94 and RY95.

14. ***Hospital Mergers***

Hospitals that have merged after October 1, 1990 and have applied for and received a single inpatient Medicare provider number, a single inpatient Medicaid provider number, and single outpatient Medicaid provider number (excluding hospital-licensed centers) shall be assigned a single combined weighted average for each of the following: SPAD, transfer, outlier, chronic, and psychiatric per diem rates. The weights shall equal each hospital's FY90 Medicaid discharges as a proportion of total Medicaid discharges for the merged hospitals, and shall be applied to the RY95 RFA inpatient rates which were calculated for each hospital. The administrative day per diem rate shall not be recalculated.

15. ***Infant and Pediatric Outlier Payment Adjustments***

a. Infant Outlier Payment Adjustment

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual infant outlier payment adjustment to acute hospitals for inpatient hospital services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths-of-stay.

(1) Data Source - The prior year's claims residing on the Division's Medicaid Information System shall be used to determine exceptionally high costs and exceptionally long lengths of stay.

(2) Eligibility - Eligibility for the Infant Outlier Payment Adjustment shall be determined as follows:

(a) Exceptionally Long Lengths of Stay: The statewide weighted average Medicaid inpatient length of stay shall be determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of total discharges for all acute hospitals in the state. The statewide weighted standard deviation for Medicaid inpatient length of stay shall also be calculated, according to the following formula:

$$\sqrt{\left(\Sigma \left(\frac{\text{MCD Discharges}}{\text{Average MCD Discharges}}\right)\left(\frac{\text{MCD Days}}{\text{MCD Discharges}}\right)^2 - \left(\frac{\Sigma\text{MCD Days}}{\Sigma\text{MCD Discharges}}\right)^2\right)}{N}$$

Where N = number of acute hospitals in Massachusetts,
MCD = Medicaid, and
Average Medicaid discharges = statewide Medicaid discharges divided by N.

The statewide weighted standard deviation for the Medicaid inpatient length of stay shall be multiplied by two, and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers shall be each hospital's threshold for Medicaid exceptionally long length of stay.

(b) *Exceptionally High Cost: For hospitals providing services to individuals under one year of age the Division shall:*

(i) First, calculate the average cost per Medicaid inpatient case for each hospital;

(ii) Second, calculate the standard deviation for the cost per Medicaid inpatient case for each hospital; and

(iii) Third, multiply the hospital's standard deviation for the cost per Medicaid inpatient discharge by two and add that amount to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers shall be each hospital's threshold for Medicaid exceptionally high cost.

(c) *Eligibility for an Infant Outlier Payment Adjustment: For each hospital providing services to individuals under one year of age, the Division shall: first, calculate the average Medicaid inpatient length of stay involving individuals under one year of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in Subsection (a) above, then the hospital shall be eligible for an outlier adjustment in the payment amount.*

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Second, calculate the cost per inpatient Medicaid case involving individuals under one year of age. If a hospital has a Medicaid inpatient case with a cost which equals or exceeds the hospital's own threshold defined in Subsection (b) above, then the hospital shall be eligible for an outlier payment adjustment.

(d) *Infant Outlier Payment to Hospitals:*
Each hospital that qualifies for an infant outlier payment adjustment shall receive an equal portion of $50,000. For example, if two hospitals qualify for the adjustment in RY95, each shall receive $25,000.

b. *Pediatric Outlier Payment Adjustment*

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual pediatric outlier payment adjustment to acute hospitals for inpatient hospital services furnished to children greater than one year of age and less than six years of age if provided by a hospital which qualifies as a disproportionate share hospital under Section 1923(a) of the Social Security Act. (See Federally-Mandated Disproportionate Share Adjustment, Section IV.2.C.2 for qualifying hospitals.) The payment shall be calculated as follows:

(1) *Data Sources - The prior year's claims residing on the Department's Medicaid Information System shall be used to determine exceptionally high costs and exceptionally long lengths of stay.*

(2) *Eligibility - Eligibility for the Pediatric Outlier Payment Adjustment shall be determined as follows:*

(a) *Exceptionally Long Lengths of Stay: The statewide weighted average Medicaid inpatient length of stay shall be determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of total discharges for all acute hospitals in the state. The statewide weighted standard deviation for Medicaid inpatient length of stay shall also be calculated, according to the following formula:*

$$\sqrt{\left(\Sigma \frac{\left(\frac{\text{MCD Discharges}}{\text{Average MCD Discharges}}\right)\left(\frac{\text{MCD Days}}{\text{MCD Discharges}}\right)^2}{N}\right) - \left(\frac{\Sigma\text{MCD Days}}{\Sigma\text{MCD Discharges}}\right)^2}$$

Where N = number of acute hospitals in Massachusetts, MCD = Medicaid, and Average Medicaid discharges = statewide Medicaid discharges divided by N.

The statewide weighted standard deviation for the Medicaid inpatient length of stay shall be multiplied by two, and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers shall be each hospital's threshold figure for Medicaid exceptionally long length of stay.

(b) *Exceptionally High Cost: For hospitals providing services to individuals greater than one year of age and less than six years of age, the Division shall:*

(i) *First, calculate the average cost per Medicaid inpatient case for each hospital;*

(ii) *Second, calculate the standard deviation for the cost per Medicaid inpatient case for each hospital; and*

(iii) *Third, multiply the hospital's standard deviation for the cost per Medicaid inpatient discharge by two and add that amount to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers shall be each hospital's threshold Medicaid exceptionally high cost.*

(c) *Eligibility for a Pediatric Outlier Payment:*
For each hospital which qualifies under Section IV.2.C.2 and provides services to individuals greater than one year of age and less than six years of age, the Division shall: first, calculate the average Medicaid inpatient length of stay involving individuals greater than one year of age and less than six years of age. If this hospital -specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in Section (a) above, then the hospital shall be eligible for a pediatric outlier payment adjustment. Second, calculate the cost per inpatient Medicaid case involving individuals greater than one year of age and less than six years of age. If a hospital has a Medicaid inpatient case with a cost which equals or exceeds the hospital's own threshold defined in Section

(b) above, then the hospital shall be eligible for a pediatric outlier payment adjustment.

(d) *Pediatric Outlier Payment to Hospitals:*
All hospitals qualifying for a pediatric outlier payment adjustment will share, in equal allotments, one half of one percent of the total funds allocated for payment to acute hospitals under the Basic Federally-Mandated Disproportionate Share Adjustment described in Section IV.2.C.2. The total funds allocated for payment to acute hospitals under the Basic Federally-Mandated Disproportionate Share Adjustment described in Section IV.2.C.2 will be reduced by the payment amount under this section.

B. Reimbursement for Unique Circumstances

1. Sole Community Hospital

The standard inpatient payment amount for a sole community hospital (as defined in Section II) shall be equal to the sum of:

97% of the hospital's actual FY90 cost per discharge, adjusted for casemix and inflation; and the hospital-specific RY95 pass-through amount per discharge, direct medical education amount per discharge and the capital amount per discharge.

Derivation of actual FY90 Medicaid costs is described in Subsection IV.2.A.2.

Adjustments were made for casemix by dividing the FY90 cost per discharge by the hospital's FY90 casemix index and then multiplying the result by the hospital's RY95 casemix index. Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.35% to reflect inflation between RY92 and RY93; by 3.01% to reflect inflation between RY93 and RY94; and by 2.80% to reflect inflation between RY94 and RY95.

Any acute hospital that qualifies as a sole community hospital and had fewer than 50 Medicaid admissions in FY90 shall be exempt from the casemix adjustment to its hospital-specific payment amount per discharge.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as sole community hospitals shall be determined by the Division.

2. Specialty Hospitals and Pediatric Units

The standard inpatient payment amount for specialty hospitals and pediatric units (as defined in Section II) shall be equal to the sum of:

97% of the hospital's actual FY90 cost per discharge, adjusted for casemix and inflation; and the hospital-specific RY95 pass-through amounts per discharge, direct medical education amount per discharge and the capital amount per discharge.

Derivation of actual FY90 Medicaid costs is described in Section IV.2.A.2.

Adjustments were made for casemix by dividing the FY90 cost per discharge by the hospital's FY90 casemix index and then multiplying the result by the hospital's RY95 casemix index. Adjustments were made for inflation by multiplying the casemix-adjusted

payment amount by 3.35% to reflect inflation between RY92 and RY93; by 3.01% to reflect inflation between RY93 and RY94; and by 2.80% to reflect inflation between RY94 and RY95.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as specialty hospitals and pediatric units shall be determined by the Division.

3. ***Public Service Hospital Providers***

The standard inpatient payment amount for public service hospital providers (as defined in Section II) shall be equal to the sum of:

97% of the hospital's actual FY90 cost per discharge, adjusted for casemix and inflation; and the hospital-specific RY95 pass-through amounts per discharge, direct medical education amount per discharge and the capital amount per discharge.

Derivation of actual FY90 Medicaid costs is described in Section IV.2.A.2.

Adjustments were made for casemix by dividing the FY90 cost per discharge by the hospital's FY90 casemix index and then multiplying the result by the hospital's RY95 casemix index. Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.35% to reflect inflation between RY92 and RY93; by 3.01% to reflect inflation between RY93 and RY94; and by 2.80% to reflect inflation between RY94 and RY95.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as public service hospital providers shall be determined by the Division.

4. ***Essential Neonatal Intensive Care Unit (NICU) Services***

Hospitals with a designated inpatient neonatal intensive care unit, as defined by the Massachusetts Department of Public Health, qualify for the payment amounts described in a. and b. below.

a. ***New Essential NICU Services***

Payment for new essential NICU services, for hospitals that began operating and admitting NICU patients during rate year 1993, shall be made as an add-on to the SPAD rate described in Section IV.2.A.2 The add-on amount shall equal the Medicaid share of reasonable costs of the NICU unit (as submitted to and

approved by the Division) divided by projected and approved FY93 total Medicaid discharges. The Medicaid share of NICU costs shall equal reasonable per discharge costs of the NICU unit multiplied by projected FY93 Medicaid NICU discharges. The hospital-specific NICU add-on was updated for inflation using factors of 3.01% and 2.80%.

b. ***Existing Essential NICU Services***

Payment for capital costs associated with existing essential NICU services, where these capital costs were recognized in the FY92 RFA reimbursement methodology, shall be made as an add-on to the capital payment amount per discharge described in Section IV.2.A.4. The add-on amount shall equal: FY92 capital costs related to the NICU unit, divided by the hospital's total FY91 non-DPU days, and then multiplied by the hospital-specific non-DPU FY91 Medicaid average length of stay (see Section IV.2.A.4.). The hospital-specific NICU add-on amount was updated for inflation using factors of 3.01% and 2.80%.

5. ***Acute Hospital Conversion Board***

If a hospital is approved for rate relief by the Acute Hospital Conversion Board (AHCB) during the term of RY95, its rates will be adjusted to ensure that the reimbursement will equal that approved by the AHCB. Once a hospital receives a letter from the AHCB conveying a vote regarding rate relief, the hospital should notify the Division in writing. The Division will then implement the rate relief in conformity with the requirements as determined by the AHCB vote.

C. Classification of Disproportionate Share Hospitals (DSHs) and Payment Adjustments

Medicaid will assist hospitals that carry a disproportionate financial burden of caring for uninsured and publicly insured persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid will make an additional payment adjustment above the rate under the RFA contract for RY95 to hospitals which qualify for such an adjustment under any one or more of the classifications listed below. Only hospitals that have an executed contract with the Division, pursuant to this RY95 RFA, are eligible for disproportionate share payments since the dollars are, in most cases, apportioned to the eligible group in relation to each other. Medicaid-participating hospitals may qualify for adjustments and may receive them at any time throughout the rate year. If a hospital's RFA contract is terminated, its adjustment shall be prorated for the portion of RY95 during which it had a contract with the Division. The remaining funds it would have received shall be apportioned to remaining eligible hospitals. The following describes how hospitals will qualify for each type of disproportionate share adjustment and the methodology for calculating those adjustments.

*The Division has added the following requirements to be eligible for DSH payments, in accordance with recent changes to federal and state law. First, hospitals must have a Medicaid inpatient utilization rate of at least 1% to be eligible for any type of DSH payment, pursuant to recently amended regulations promulgated by the Rate Setting Commission and found at 114.1 CMR 36.13(10) (attached as **Exhibit 4**). Second, the total amount of DSH payment adjustments awarded to any hospital shall not exceed the costs incurred during the year of furnishing hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third party coverage less payments received by the hospital for medical assistance and by uninsured patients ("unreimbursed costs"); however, the Division may award to publicly-owned or operated hospitals with high disproportionate share, as defined in 42 U.S.C. §1396r-4(g)(2)(B), a DSH payment adjustment up to 200% of unreimbursed costs incurred in FY 1995 if the Governor certifies to the U.S. Secretary of Health and Human Services that payment adjustments which exceed 100% of the unreimbursed costs are used for health services during the year (hereinafter the "cost limit rule"). See 114.1 CMR 36.13(10) (attached as **Exhibit 4**). This cost limit rule is made effective, pursuant to 42 U.S.C. §§1396r-4(g)(1)(B) and (2)(A), on July 1, 1994 for public hospitals and on July 1, 1995 for private hospitals.*

When a hospital applies to participate in Medicaid, its eligibility and the amount of its adjustment shall be determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following DSH classifications (1 through 4, below). Some disproportionate share adjustments may require recalculation due to changes in circumstances, such as new or closing hospitals. Hospitals will be informed if the adjustment amount will change due to reapportionment among the qualified group and will be told how overpayments or underpayments by the Division will be handled at that time.

*1. **High Public Payor Hospitals: Sixty-Three Percent Hospitals***
(Total Funding: $11,700,000)

The eligibility criteria and payment formula for this DSH classification are specified in regulations of the Rate Setting Commission at 114.1 CMR 36.13(10)(a)

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